Home Health Data Elements-Cross Reference
HCFA-485 Home Health Certification and Plan of Treatment

Form Item	Form Description	Location in Electronic Record	Comments
1	Patient's HICN	RT 30, Field 7 RT 74, Field 5	
2	SOC Date	RT 71, Field 5	Start of Care Date.
3	Certification Period	RT 71, Field 6-7	
4	Medical Record Number	RT 20, Field 25 RT 74, Field 6	
5	Provider Number	RT l0, Field 6	
6	Patient's Name and Address	RT 20, Fields 4-6 and 13-17 RT 74, Fields 7-9	Patient's Name present RT 74.
7	Provider's Name and Address	RT 10, Fields 13-17	
8	Date of Birth	RT 20, Field 8 RT 74, Field 10	
9	Sex	RT 20, Field 7 RT 74, Field 11	
10	Medications	RT 73	Narrative
11	Principal Diagnosis ICD-9-CM Code	RT 70, Field 4 RT 74, Field 12	ICD-9-CM code only and most recent date (i.e., date of onset or date of exacerbation).
	Date Onset/Exacer-bation	RT 71, Field 8	
12	Surgical Procedure ICD-9-CM Code Date of Procedure	RT 71, Field 9 RT 71, Field 10	ICD-9-CM procedural code only and date for the one procedure most relevant to the care being provided.
13	Other Pertinent Diagnoses ICD-9-CM Codes	RT 70, Fields 5-8 RT 74, Fields 13-16	ICD-9-CM diagnostic codes and most recent date (i.e., onset or exacerbation).
	Dates of Onset/ Exacerbation	RT 71, Fields 11-14	

Home Health Data Elements-Cross Reference
HCFA-485 Home Health Certification and Plan of Treatment (Cont)

Form Item	Form Description	Location in Electronic Record	Comments
14	DME and Supplies	RT 61 RT 73	HCPCS codes for DME billed. Narrative.
15	Safety Measures	RT 73	Narrative.
16	Nutritional Requirements	RT 73	Narrative.
17	Allergies	RT 73	Narrative.
18A	Functional Limitations	RT 71, Field 15	Code for each functional limitation.
18B	Activities Permitted	RT 71, Field 16 RT 73, 48617	Code for each activity indicated. Description of other, 18A 18B.
19	Mental Status	RT 71, Field 17 RT 73, 48616	Codes for each description indicated. Description of other.
20	Prognosis	RT 71, Field 18	Code for prognosis indicated.
21	Orders for Disciplines and Treatments	RT 73	Narrative.
22	Goals/Rehabilitation Potential/ Discharge Plans	RT 73	Narrative.
23	Verbal Start of Care Date	RT 71, Field 19	
24	Attending Physician's Name and Address	RT 71, Fields 20-23	Name and ZIP code.
25	Date HHA Received Signed POT	Not present	Present on hardcopy form in agency file if applicable.
26	Physician Certification	Not present -	See Item 27
27	Attending Physician's Signature and Date	Not present	The physician's certification signature must be present on the hardcopy form retained in the agency files. The form must be dated by the physician or contain a date in Item 25.

Home Health Data Elements-Cross Reference
HCFA-486 Medical Update and Patient Information

Form Item	Form Description	Location in Electronic Record	Comments
1	HICN No.	RT 30, Field 7 RT 74, Field 11	
2	SOC Date	RT 71, Field 5	
3	Certification Period	RT 71, Fields 6-7	
4	Medical Record Number	RT 20, Field 25 RT 74, Field 6	
5	Provider Number	RT 10, Field 6	
6	Patient's Name	RT 20, Field 4-6 RT 74, Fields 7-9	
7	Provider Name	RT 10, Field 13	
8	Medicare Covered N-(noncovered)	RT 71, Field 24	Y-(covered)
9	Date Physician Last Saw Patient	RT 71, Field 25	
10	Date Last Contacted Physician	RT 71, Field 26	
11	Patient Receiving Care in l86l Jl Facility	RT 71, Field 27	Y-(yes), N-(no), D-(do not know)
12	Certification/Recertification/ Modified	RT 71, Field 28	C-(Cert), R-(Recert) M-(Modified)
13	Specific Services and Treatments	RT 72	A separte 72 record is required for each discipline ordered.
14	Dates of Last Inpatient Stay-	RT 71, Fields 29-30	

Home Health Data Elements-Cross Reference
HCFA-486 Medical Update and Patient Information (Cont)

Form Item	Form Description	Location in Electronic Record	Comments
15	Type of Facility	RT 71, Field 31	
16	Updated Information	RT 73	Narrative.
17	Functional Limitations/ Reasons Homebound/Prior Functional Status	RT 73	Narrative.
18	Supplementary Plan of Treatment on File	RT 73	Narrative. Present only if applicable.
19	Unusual Home/Social Environment	RT 73	Narrative. Optional.
20	Indicate times when the HHA made visit(s) and the patient was not at home and reasons for absence.	RT 73	Narrative.
21	Specify known medical and/or nonmedical reasons patient regularly leaves home and frequency	RT 73	Narrative.
22	Signature and Date of Nurse or Therapist Completing Form	Not present HHA's files.	Must be on hardcopy form retained in the

Record Type 71 - Plan of Treatment and Patient Information –
Data Definitions and Codes

HCFA/486	Data Element	Definition	Cross Reference Field
Data ID	Identifies submittal of 485 and 486 data or 486 data only l = 485 and 486 2 = 486 only Required for abbreviated POC.	4	-----
SOC Date	Date covered home health services began. Required for abbreviated POC.	5	485-2
Certification Period	From/To dates of period to be covered by this plan of treatment. Required for abbreviated POC.	6-7	" 3
Date of Onset/ Exacerbation of Principal Diagnosis	The date of onset or date of exacerbation of the diagnosis shown as principal in Record Type 70 or 74. Required for abbreviated POC.	8	" 11
Surgical Procedure Codedescribing the surgical	The ICD-9-CM code procedure (if any) most relevant to the care being rendered. If applicable, required for abbreviated POC.	9	" 12
Date of Surgical Procedure	The date the surgery (Field 9) was performed. If applicable, required for abbreviated POC.	10	" 12
Dates of Onset/ Exacerbation	The date of onset or exacerbation of the secondary diagnoses	11-14	" 13

Record Type 71 - Plan of Treatment and Patient Information - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-485/486
	shown in Record Type 70 or 74. The related dates are entered in the same order as the secondary diagnosis codes.		
Functional Limitations	Codes describing the patient's functional limitations as assessed by the physician. "Other" is described in Record Type 73 (48617). l= Amputation 2= Bowel/Bladder (Incontinence) 3= Contracture 4= Hearing 5= Paralysis 6= Endurance 7= Ambulation 8= Speech 9= Legally Blind A= Dyspnea with Minimal Exertion B= Other A minimum of one must be present on the abbreviated POC.	15	" 18A
Activities Permitted	Codes describing the activities permitted by the physician or for which physician's orders are present. "Other" is described in Record Type 73 (48617). l= Complete Bedrest 2= Bedrest BRP 3= Up as Tolerated 4= Transfer Bed/Chair 5= Exercises Prescribed 6= Partial Weight Bearing 7= Independent at Home	16	485-18B

Record Type 71 - Plan of Treatment and Patient Information - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-485/486
	8= Crutches 9= Cane A= Wheelchair B= Walker C= No Restrictions D= Other		
	A minimum of one must be present for the abbreviated POC.		
Mental Status	Codes describing the patient's mental condition. "Other" is described in Record Type 73 (48616). 1 = Oriented 2 = Comatose 3 = Forgetful 4 = Depressed 5 = Disoriented 6 = Lethargic 7 = Agitated 8 = Other	17	485-19
	A minimum of one must be present for the abbreviated POC.		
Prognosis	Code indicating physician's prognosis for patient. 1 = Poor 2 = Guarded 3 = Fair 4 = Good 5 = Excellent	18	485-20
Verbal Start of Care Date MMDDYY	The date the agency received the verbal orders from the physician, if this is prior to the date care started.	19	485-23
(Attending) Physician's Name	The name of the attending physician who established the plan of treatment.	20-22	485-24

Record Type 71 - Plan of Treatment and Patient Information - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-485/486
o Last Name o First Name o Initial	(This should be the physician who certifies and recertifies the medical necessity of the home health visits and/or services.)		
Physician's ZIP Code	The nine-digit ZIP code from the address field on the HCFA-485.	23	485-24
Medicare Covered	The following applicable codes: Y = Covered N = Noncovered	24	486-8
Date Physician Last Saw Patient	Date if (known) that patient was last seen by physician.	25	486-9
Date Agency Last Contacted Physician	Date of agency's most recent physician contact. Purpose stated in Record Type 73 (48616).	26	486-10
Patient Receiving Care in l86l J1 Facility	Y = Yes N = No D = Do not know	27	486-11
Cert/Recert/Mod	One of following applicable codes: C = Certification R = Recertification M = Modified	28	486-12
Dates of Last Inpatient Stay	From/To dates of most recent inpatient stay. If applicable, required for abbreviated POC.	29-30	486-14
Type of Facility	Coding indicating type of facility from which patient was most recently discharged.	31	486-15

Record Type 72 - Specific Services and Treatments - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-485/486
	A = Acute S = SNF I = ICF R = Rehabilitation Facility O = Other		
	For abbreviated POC, if last inpatient stay is present, type of facility is required.		
Discipline	Code indicating discipline(s) ordered by physician. SN = Skilled Nursing PT = Physical Therapy ST = Speech Therapy OT = Occupational Therapy MS = Medical Social Worker AI = Home Health Aide	5	486-13
Visits (This Bill) Rel. to Prior Certification	Total visits on this bill rendered prior to recertification "To" date.	6	486-13
	If applicable, required for abbreviated POC.		
Frequency of Visits	Code indicating frequency of visits during the period covered by the plan of treatment. Code is 3 positions. Position 1 is a numeric expression of number of times. Positions 2-3 are an alpha expression of period of time. Enter the frequency codes in the order being rendered. n = l-9 xx = da = day wk = week mo = month	7	486-13

Record Type 72 - Specific Services and Treatments -
Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-485/486
	q = every n days bb = for PRN visits A minimum of one group must be present for the abbreviated POC.		
Duration of Visits	Code indicating length of time type visits will be rendered at the frequency shown. The code is 3 positions and is always numeric except for PRN ORDERS. nnn = 00l-999 xxx = PRN The period of time for the duration is, with the exceptions below, always the same as the period of time in the frequency. Exceptions: q (every) frequency is always a duration of nnn days. bb (blank) frequency is always PRN duration. Examples: Daily visits times l0 days l da l0 One visit every 2 months l qb 60 Two visits PRN 2 bb PRN A minimum of one group must be present for the abbreviated POC.	7	486-13

Record Type 72 - Specific Services and Treatments -
Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-485/486
Treatment Codes	Codes describing the treatment ordered by the physician. Show in ascending order. Valid codes are: A01-A30 = Skilled Nursing B01-B15 = Physical Therapy C01-C09 = Speech Therapy D01-D11 = Occupational Therapy E01-E06 = Medical Social Services F01-F15 = Home Health Aide One or more codes must be present for each discipline (e.g., SN, PT, etc.). Required for abbreviated POC.	8	486-13
Total Visits Projected This Cert.	Total Covered visits to be rendered by each discipline during the period covered by the plan of treatment. Include PRN visits. Required for abbreviated POC.	9	486-13

Record Type 73 - Medical Update and Patient Information - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference
Medications	The physician's orders for all medications (dose, frequency, route of administration). The letter "N" will be used after New Medications, letter C for "Changed" orders. Show none if no medication are ordered.		485-10
Durable Medcal (DME) and Medical Supplies	The DME ordered by the physician. All nonroutine supplies which are required to carry out the physician's orders.		485-14
Safety Measures	The physician's instructions for safety measures.		485-15
Nutritional Requirments	Physician's order for diet. This includes therapeutic diet and/or any specific dietary requirements and fluid restrictions.		485-16
Allergies	Patient's allergies, e.g., medications, foods, adhesive tape, iodine, etc.		485-17
Orders for Disciplines and Treatments	Specific physician orders.		485-21
Goals/Rehabilitation Potential/ Discharge Plans	Succinct description of information provided by physician.		485-22

Record Type 73 - Medical Update and Patient Information - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference
Updated Information	New orders, clinical facts, discipline summaries.		486-16
Functional Limitations/Reason Homebound	Expansion of functional limitations and description of the reason homebound. "Other" is described where indicated for functional limitations and/or activities permitted.		486-17
Supplementary Plan	Description of services on a supplemental plan of treatment.		486-18
Unusual Home/Social Environment	Description of home/social environment which would further justify need for services or homebound condition.		486-19
Types and Reasons Patient Not at Home	Number of times agency made a visit and patient was absent from home and reason for absence if known.		486-20
Medical/Nonmedical Reasons Patient Leaves Home	Reasons patient leaves home and frequency of occurrence. Record will also indicate if patient does not leave home.		486-21

RECORD TYPE 74 - PATIENT INFORMATION DATA DEFINITIONS AND CODES

This record is used to submit Forms HCFA-485/486, ambulance, SNF, rehabilitative services information (Forms HCFA-700/701), and medical documentation data without an accompanying bill record (UB-92).

Data Element	Definition	Field
Attachment Submission Status	Code describes if it is an original or updated submission. See Addendum B. A_ = Add U_ = Update	4
HICN	Code shows Patient's HICN.	5
Medical Record Number	Number used to access patient's medical record.	6
Patient Name	Patient's name.	
Last name		7
First name		8
Initial		9
Date of Birth	Patient's date of birth shown as 8 digits (MMDDYYYY).	10
Sex	M - (Male) F - (Female). U - (Unknown)	11
Principal Diagnosis	Enter the ICD-9-CM code for the diagnosis most related to the current plan of treatment.	12
Secondary Diagnosis	Enter up to four secondary diagnoses pertinent to the case. Use ICD-9-CM codes.	13-16
Start of Care/Admission Date	Enter the 6-digit date (MMDDYY).	17
Statement Covers Period	Enter the 6 digit (MMDDYY) start and end dates for the billing period.	
From Date		18
Thru Date		19
Provider Number	Enter the unique Medicare number assigned to the provider.	20
Internal Control/ Document Control Number (ICN/DCN)	Enter the unique number assigned to an individual claim by the claims processing system. Providers would receive this number from you as part of a request for attachment information.	21

(Next page is D-19)

Outpatient Rehabilitation Data Element Cross-Reference
HCFA-700 Plan of Treatment for Outpatient Rehabilitation
UB-92 Flat File Records

Form Item	Form Description	Location in Electronic Record	Comments
1	Patient's Name	RT 20, fields 4-6 RT 74, fields 7-9	
2	Provider Number	RT l0, field 6 RT 74, field 20	Institution number
3	Patient's HICN	RT 30, field 7 RT 74, field 5	
4	Provider Name	RT 10, field 12	Institutional provider
5	Medical Record Number	RT 20, field 25 RT 74, field 6	
6	Onset Date	RT 40, fields 8-27 Occurrence code 11 RT 77, format A field 22	Onset date of primary medical diagnosis or most recent exacerbation.
7	SOC Date	RT 20, field 17 RT 74, field 17 RT 77, format A field 24	Start of care date.
8	Type field	RT 77, all formats field	Therapy type billed. 5is named "Discipline."
9	Primary Diagnosis	RT 70, field 4 RT 74, field 12	ICD-9-CM code relating to the disorder and relating to 50% or more of the effort in the plan of treatment.
10	Treatment Diagnosis	RT 77, format A field 29 (Code) RT 77, format A field 30 (Narrative)	ICD-9-CM code only. Treatment diagnosis for services rendered. Conditional. If code not present on RT 77, format A, field 29, narrative diagnosis must be entered.
11	Visits From Start of Care	RT 77, format A field 26	Cumulative total visits (sessions) inclusive of the first and last day of the billing period.
12	Plan of Treatment/ Functional Goals	RT 77, format N field 6	Narrative. Type of narrative is noted by narrative type indicator.

Outpatient Rehabilitation Data Element Cross-Reference
HCFA-700 Plan of Treatment for Outpatient Rehabilitation
To UB-92 Flat File Records

Form Item	Form Description	Location in Electronic Record	Comments
13	Signature	RT 77, format A fields 11-16 field 11 (UPIN) fields 12-14 (Name) field 15 (Designation) field 16 (Date)	Professional establishing plan of treatment. Noted by rehabilitation professional UPIN or name, professional designation, and signature date.
14	Frequency/Duration	RT 77, format R field 13	See Addendum B for code structure.
15	Physician's Signature	RT 77, format A field 6	Valid UPIN only.
16	Date	RT 77, format A field 9	Date of physician signature on plan of treatment.
17	Certification	RT 77, format R fields 9, 11	Period covered in plan of treatment.
		RT 77, format R field 17	Certification status. PT, OT, and ST must be certified.
18	On File	No electronic format	
19	Prior Hospitalization	RT 77, format A fields 18, 20	Inclusive dates of recent hospitalization pertinent to plan of treatment.
20	Initial Assessment	RT 77, format N field 6	Narrative. Type of narrative is noted by narrative type indicator.
21	Functional Level (end of billing period)	RT 77, format N field 6	Narrative. Type of narrative is noted by narrative type indicator.
	Continue Services or DC Services	RT 77, format R field 14	Code to indicate choice. at end of treatment period.
22	Service Dates	RT 74, fields 18-19	Should match claim date from original claim.

Outpatient Rehabilitation Data Element Cross-Reference
HCFA-701 Updated Plan of Progress for Outpatient Rehabilitation
To UB-92 Flat File Records

Form Item	Form Description	Location in Electronic Record	Comments
1	Patient's Name	RT 20, fields 4-6 RT 74, fields 7-9	
2	Provider Number	RT l0, field 6 RT 74, field 20	Institution number
3	Patient's HICN	RT 30, field 7 RT 74, field 5	
4	Provider Name	RT 10, field 12	Institutional provider
5	Medical Record Number	RT 20, field 25 RT 74, field 6	
6	Onset Date	RT 40, fields 8-27 Occurrence code 11 RT 77, format A field 22	Onset date of primary medical diagnosis or most recent exacerbation.
7	SOC Date	RT 20, field 17 RT 74, field 17 RT 77, format A field 24	Start of care date.
8	Type	RT 77, all formats field 5.	Therapy type billed. Field is named "Discipline."
9	Primary Diagnosis	RT 70, field 4 RT 74, field 12	ICD-9-CM code relating to the disorder and relating to 50% or more of effort in the plan of treatment.
10	Treatment Diagnosis	RT 77, format A field 29 (Code) RT 77, format A field 30 (Narrative)	ICD-9-CM code only. Treatment diagnosis for services rendered. Conditional. If code not present in RT 77, format A, field 29, narrative diagnosis must be entered.
11	Visits From Start of Care	RT 77, format A field 26	Cumulative total visits (sessions) inclusive of the first and last day of the billing period.
12	Frequency/Duration	RT 77, format R field 13	See Addendum B for code structure.

Outpatient Rehabilitation Data Element Cross-Reference
HCFA-701 Updated Plan of Progress for Outpatient Rehabilitation
To UB-92 Flat File Records

Form Item	Form Description	Location in Electronic Record	Comments
13	Current Plan Update/ Functional Goals	RT 77, format N field 6	Narrative. Type of narrative is noted by narrative type indicator.
14	Recertification fields 9, 11	RT 77, format R treatment.	Period of plan of
		RT 77, format R field 17	Certification status. PT, OT, and ST must be certified.
15	Physician's Signature	RT 77, format A field 6	Valid UPIN only.
16	Date	RT 77, format A field 9	Date of physician signature on plan of treatment.
17	On File	No electronic format	
18	Reasons for Continuing Treatment this Billing Period	RT 77, format N field 6	Narrative. Type of narrative is noted by narrative type indicator.
19	Signature	RT 77, format A field 11-15 field 11 (UPIN) fields 12-14 (Name) field 15 (Designation)	Professional establishing plan of treatment. Noted by rehabilitation professional's UPIN or name and professional designation.
20	Date	RT 77, format A field 16	Rehabilitation professional signature date on plan of treatment.
21	Continue Services or DC Services	RT 77, format R field 16	Code to indicate choice at end of treatment period.
22	Functional Level (end of billing period)	RT 77, format N field 6	Narrative. Type of narrative is noted by narrative type indicator.
23	Service Dates	RT 74, fields 18-19	Match claim data from original claim.

Record Type 77 - Rehabilitative Services Record
Format A - Administrative Data
Valid Data Definitions and Codes

See Addenda B for definitions of record type (field 1), sequence number (field 2), and patient control number (field 3).

Data Element	Definition	Field	Cross Reference HCFA-700/701
Record Format	Indicates the format type of record type 77 submitted. A - Administrative Data Required.	4	
Discipline	Indicates type of rehabilitative services the plan of treatment was established for. SN - Skilled Nursing PT - Physical Therapy ST - Speech Language Pathology OT - Occupational Therapy MS - Social Work CR - Cardiac Rehabilitation RT - Respiratory (Inhalation) Therapy PS - Psychiatric Services Required.	5	700 and 701-8
Attending Physician Number (UPIN)	Identifies the physician who has primary responsibility for the patient's medical care and treatment. Required.	6	700 and 701-15
Physician Referral Date (MMDDYY)	Date physician referred patient for evaluation and treatment. Required.	7	-----
Physician Signature Date on Plan of Treatment (MMDDYY)	Indicates the date of written physician verification of the plan of treatment for outpatient rehabilitative services. Required.	9	700 and 701-16

Record Type 77 - Rehabilitative Services Record
Format A - Administrative Data
Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-700/701
Rehabilitation Professional Identifier (UPIN)	Identifies the rehabilitation professional (e.g., therapist, nurse, psychologist, social worker) establishing the plan of treatment or recommending the need for continuing or discontinuing care. Conditional. If this field is blank, RT 77, format A, fields 12 and 13 must contain a narrative text name.	11	700-13 701-19
Rehabilitation Professional Name	Identifies the rehabilitation professional (e.g., therapist, nurse, psychologist) establishing the plan of treatment and/or recommending continued need (or discontinuance) of care.	12-14	700-13 701-19
Last Name	Conditional. Required if RT 77, format A, field 11 is blank.	12	
First Name	Conditional. Required if RT 77, format A, field 11 is blank.	13	
Middle Initial	Optional.	14	
Professional Designation of Rehabilitation Professional	Indicates the professional status and designation (e.g., LCSW, RN) of the rehabilitation professional establishing the plan of treatment for outpatient rehabilitative services. Required.	15	700-13 701-19
Rehabilitation Professional Signature Date on Plan of Treatment (MMDDYY)	Indicates date the rehabilitation professional verified and signed the plan of treatment. Required.	16	701-20

Record Type 77 - Rehabilitative Services Record
Format A - Administrative Data
Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-700/701
Prior Hospitalization Dates (From - Through) (MMDDYY)	Dates indicate the inclusive dates of recent hospitalization (first to discharge day) pertinent to the patient's current plan of treatment. Conditional. If the From Date is present, the Through Date must be present. The submission of this information is optional. Providers should indicate this only when applicable, and it should be sent only with initial plans of treatment.	18, 20	700-19
Date of Onset/ Exacerbation of Principal Diagnosis (MMDDYY)	Date of onset or exacerbation for the patient's primary diagnosis requiring rehabilitative services. If exact date is unknown, 01 will be entered for day. Required.	22	700 and 701-6
Admission Date/Start of Care Date (MMDDYY)	Indicates date services/ care began. Required.	24	700 and 701-7
Total Visits From Start of Care (SOC)	Represents the cumulative total visits (sessions) since the SOC through the last visit of the current billing period. Required. Must match value codes submitted on the original claim. 50 - PT visit 51 - OT Visit 52 - ST Visit 53 - CR	26	700 and 701-11

Record Type 77 - Rehabilitative Services Record
Format A - Administrative Data
Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-700/701
Date of Most Recent Event Requiring Cardiac Cardiac Rehabilitation (MMDDYY)	Indicates date of most recent medical event requiring cardiac rehabilitative services. Conditional. Required if discipline (RT 77, format A, field 5) is CR.	27	------
Treatment Diagnosis Code (ICD-9)	ICD-9 code for the treatment diagnosis for which fifty percent (50%) or more of the rehabilitative services are rendered. Conditional. If field is blank, RT 77, format A, field 29 (Treatment Diagnosis Narrative) is required.	29	700 and 700-10
Treatment Diagnosis (Narrative)	Treatment diagnosis for which fifty percent (50%) or more of the rehabilitative services are rendered. Conditional. Required if RT 77, format A, field 29 (Treatment Diagnosis Code) is blank. This field will become filler on October 1, 1997. Providers must submit only ICD-9-CM codes after that date in RT 77, format A, field 29.	30	700 and 701-10

Record Type 77 - Rehabilitative Services Record
Format R - Treatment Data
Data Definitions and Codes

See Addenda B for definitions of Record Type (field 1), sequence number (field 2), and patient control number (field 3). Data element definitions for discipline (field 5) is identical on all RT 77 records. (See definition in format A.)

Data Element	Definition	Field	Cross Reference HCFA-700/701
Record Format	Indicates the format type of record type 77 submitted. R - Treatment Data Required.	4	-----
Plan of Treatment (POT) Status (Initial/Update)	Indicates whether plan of treatment is original or updated. 700 - Original Plan of Treatment 701 - Updated Plan of Treatment Required.	6	------
Plan of Treatment (POT) - Date Established (MMDDYY)	Indicates date plan of treatment was established by the rehabilitation professional. Required.	7	------
Plan of Treatment (POT) - Period Covered (From - Through) (MMDDYY)	Period defining the inclusive dates covered by this plan of treatment. Required.	9, 11	700-17 701-14
Frequency/Duration of Therapy	Indicates the frequency and duration of visits (sessions) during the period covered by the plan of treatment. Required.	13	700-14 701-12
Frequency Number (position 1 of code)	Indicates the number of visits (sessions) per frequency period during the period covered by the plan of treatment. 1-9 are valid values.		

Record Type 77 - Rehabilitative Services Record
Format R - Treatment Data
Data Definitions and Codes (Cont.)

Data Element	Definition	Field	Cross Reference HCFA-700/701
Frequency Period (positions 2-3 of code)	Indicates the unit of time visits (sessions) are to occur in during the period covered by the plan of treatment. DA - Day WK - Week MO - Month Q(space) - every n days where n = duration (2 space) - PRN (whenever necessary		
Duration (positions 4-6 of code)	Indicates the duration of visits (sessions) in days during the period covered by the plan of treatment. 001-999 - duration in days when frequency period is a set time period. PRN - when frequency period is 2 spaces. Indicates "whenever necessary."		
Estimated Date of Completion of Outpatient Rehabilitation (MMDDYY)	Indicates an approximate date for discontinuance of rehabilitative services for a single discipline (e.g., PT, OT) due to goal achievement. Required.	14	-----
Service Status (Continue /Discontinue)	Indicates whether or not rehabilitative services should continue to achieve functional goals. This is indicated at the end of the period covered in the plan of treatment. 1 - Continue 2 - Discontinue Required.	16	700 and 700-21

Record Type 77 - Rehabilitative Services Record
Format R - Treatment Data
Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-700/701
Certification Status	Indicates if submitted information for plan of treatment is a certification, re-certification, or not required. 01 - Certification 02 - Recertification 99 - Not Applicable Required. For discipline (RT 77) field 5) values PT, OT, and ST, only values of 01 and 02 are valid.	17	-----
	If the value for plan of treatment status (RT 77, format R, field 6) is 700, then value in this field must be 01 or 99. If the value for plan of treatment status (RT 77, format R, field 6) is 701, then value in this field must be 02 or 99. If the value for this field is 02, the date of last certification (RT 77, format R, field 18) is required.	17	-----
Date of Last Certification (MMDDYY)	Indicates date last plan treatment was certified, if applicable. Conditional. Required if the value for certification status (RT 77, format R, field 17) is 02.	18	-----
Route of Administration - IM medications are being	Identifies if any administered intramuscularly. Y - If present, equals Yes. N - If present, equals No.	20	-----

Record Type 77 - Rehabilitative Services Record
Format R - Treatment Data
Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-700/701
	Optional. Should be used only for psychiatric services.		
Route of Administration - IV medications are being	Identifies if any administered intravenously. Y - If present, equals Yes. N - If present, equals No. Optional. Should be used only for psychiatric services.	21	-----
Route of Administration - PO medications are being	Identifies if any administered by mouth. Y - If present, equals Yes. N - If present, equals No. Optional. Should be used only for psychiatric services.	22	-----
Drugs Administered (Narrative)	Identifies medications administered as part of a psychiatric services plan of treatment. Optional. Should be used only for psychiatric services.	23	-----
Prognosis	Code indicating the rehabilitation professional's prognosis for patient rehabilitation. 1 = Poor 2 = Guarded 3 = Fair 4 = Good 5 = Excellent Required.	24	700-21 701-22

Record Type 77 - Rehabilitative Services Record
Format N - Narrative Text
Data Definitions and Codes

See Addenda B for definitions of Record Type (field 1), sequence number (field 2), and patient control number (field 3). Data element definition for discipline (field 5) is identical on all RT 77 records. (See definition in format A.)

Data Element	Definition	Field	Cross Reference HCFA-700/701
Record Format	Indicates the format type of record type 77 submitted. N - Narrative text Required.	4	-----
Narrative Type Indicator	Indicates type of narrative which follows relative to the plan of treatment. See §3908.4 for each narrative description. 01 - Medical History/ Prior Level of Function 02 - Initial Assessment 03 - Functional Goals 04 - Plan of Treatment 05 - Progress Report 06 - Continued Treatment 07 - Justification for Admission 08 - Symptoms/Present Behavior Required.	6	700-12, 20, 21 701-13, 18, 22
Free Form Narrative	Free form narrative description. Text should include information as requested/required by your medical review instructions. Required.	7	700-12, 20, 21 701-13, 18, 22